STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. BUILDING 00 B. WING	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was the Investigation of Complaint IN00111956. Complaint IN00111956-Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F225, F309, F323, F502, and F514. Survey dates: July 22, 23, 24, 25, 26, 2012 Facility number: 003075 Provider number: 155695 AIM number: 200364160 Survey team: Ann Armey, RN TC Census bed type: SNF/NF: 85 Total: 85 Census payor type: Medicare: 9 Medicaid: 65 Other: 11 Total: 85 Census: 12 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after August 25, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on July 31, 2012 by Bev Faulkner, RN			

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on interview and record review, the facility failed to notify the physician when a resident refused his medication. This deficiency affected 1 of 1 resident reviewed, for the refusal of medication, in	F0157	**F157 – Notify of Changes (Injury/Decline/Room, etc)** It is the practice of this provider to promptly notify the resident, consult with resident's physician, notify resident's legal	08/25/2012

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	a sample of 12. (Resident #F) Finding include: The clinical record of Resident #F was reviewed on 7/24/12 at 10:00 a.m. and indicated the resident was admitted to the facility on 3/16/12 with diagnoses which included but were not limited to, seizure disorder, anxiety and diabetes mellitus. The July 2012 MAR (Medication Administration Records) indicated the resident was to receive Megace 400 mg twice daily with meals for a poor appetite. The Megace was circled as refused on at least, 10 of 25, 5:00 p.m. doses (7/1, 3, 5, 11, 12, 14, 18, 20, 23, and 25/12) and on at least, 6 of 25, 8:00 a.m. doses (7/1, 2, 3, 4, 5, and 24/12). Documentation on the back of the MAR indicated Resident #F also refused Lovenox (a medication to reduce blood clots) 40 mg injections on 7/19/12 and 7/21/12. There was no documentation the physician was consulted about Resident #F's refusal of the Megace and Lovenox. On 7/25/12 at 9:30 a.m., the DON (Director of Nursing) indicated there was no documentation the physician was		representative or interested family when there is a significant condition change in the resident's physical, mental or psychosocial status and/or the need to alter treatment. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident F –* physician is aware of this resident's continued medication refusals, and will be notified of any further refusals of medication. The resident has experienced no negative outcome as a result of this finding. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected by this finding. An all resident chart audit will be conducted by the Nurse Management Team to ensure the physician has been notified regarding resident change in condition and/or refusal of medications. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A nursing in-service will be conducted by the DNS/designee on or before 8/25/12. This in-service will include review of the facility policy titled, "Resident Change in Condition" including notification to physician regarding	

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	notified about the refusal of the Megace and Lovenox. The DON indicated the physician was in the facility on 7/24/12 and talked to the resident about his refusal to take his medication. The Resident Refusal of Medications, Treatments policy, revised 3/2010, provided by the DON, was reviewed on 7/25/12, and indicated "...5. If a resident refuses administration of a medication or treatment for three (3) consecutive days, the physician ...will be contacted and made aware of the refusals. 6. Documentation of the physician/family notification and any new orders/recommendations will be charted in the nursing progress notes..." This Federal tag related to Complaint IN00111956. 3.1-5(a)(3)		resident medication refusals. Continued compliance with prompt notification will be monitored through review of nursing progress notes during the daily clinical meeting by the DNS/designee. In addition, the MAR will be reviewed by the Nurse Management Team during the weekday clinical meeting to ensure any resident medication refusals are addressed and followed up with promptly per facility policy. Charge nurse to review on weekend days. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI Tool titled, “Refusal of Medications, Treatments” daily for 3 weeks, weekly for 3 weeks, bi-weekly for 3 weeks and monthly for six months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 8/25/12.	

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F0225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to investigate the cause of	F0225	**F225 – Investigate/Report** It is the practice of this provider that all alleged violations involving	08/25/2012

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	bruises, which were identified on dependent residents. This deficiency affected 4 of 4 residents with incidents of bruising, which were reviewed in a sample of 12. (Resident #K, #E, #B, #C) Findings include: 1. The clinical record of Resident #K was reviewed on 7/25/12 at 11:00 a.m., and indicated the resident was admitted to the facility on 10/1/06, with diagnoses which included but were not limited to, dementia and blindness. The resident was placed in hospice care on 8/2/11 and expired on 7/23/12. On 6/12/12 at 2:29 p.m., nursing notes indicated there was a bruise on the right lower back measuring 2.5 cm by 1.8 cm with no redness or warmth noted. The note indicated the physician and power of attorney were notified. On 6/21/12 at 2:46 p.m., nursing notes indicated the resident presented with a purple area on the left upper arm. The note indicated there was no pain and the resident's range of motion was within normal limits. The MDS (Minimum Data Set) Assessment, dated 7/10/12, indicated the		mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and thoroughly investigated per facility policy. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident #E, B, C –* physician and families have been updated and informed of each resident's current skin condition. These residents experienced no negative outcome as a result of this finding. #K no longer resides at facility.***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents are at risk to be affected by this finding. Weekly Skin Assessments will be completed on all residents as well as skin inspections during routine bathing and shower care. Shower sheets will be reviewed during weekday clinical meetings. Charge nurse to review showers sheets on weekend days. Any new areas of bruising, discoloration will be promptly investigated and followed up with to determine cause. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A	

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	resident had severe cognitive impairments and required either extensive assistance or was totally dependent for transfer, dressing, eating toileting, hygiene and bathing. On 7/26/12 at 12:15 p.m., the DON (Director of Nursing), who had just begun employment at the facility, was interviewed and indicated she could not find documentation to show the bruises on the left upper arm and lower back, were investigated for causative factors. 2. The clinical record of Resident #E was reviewed on 7/25/12 at 1:00 p.m., and indicated the resident was admitted to the facility on 4/21/05 with diagnoses which included but were not limited to, Alzheimer's disease. On 6/11/12 at 9:30 p.m., Resident #E was noted to have a bruise on the left foot and the physician ordered an x-ray. On 6/12/12 at 11:29 a.m., nursing notes indicated the left foot remained dark across the whole foot but was darker at the proximal digits. On 6/12/12 at 1:12 p.m., nursing notes indicated the x-rays came back negative for fractures. The Minimum Data Set Assessment, dated 7/10/12, indicated the resident had		nursing in-service will be held on or before 8/25/12. The DNS/designee is responsible for conducting this in-service. This in-service will include review of the policy titled, "Unusual Occurrences for Residents & Visitors" with a specific focus on injuries of unknown origin such as bruising and discolorations. Weekly Skin Assessments will be completed on all residents as well as skin inspections during routine bathing and shower care. Shower sheets will be reviewed during weekday clinical meetings by the DNS/designee. Showers sheets will be reviewed on weekend days by Charge nurse. Any new areas of bruising, discoloration will be promptly investigated and followed up with to determine cause by DNS/designee. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The DNS/designee will be responsible for completion of the CQI Audit Tool titled, "Bruises" daily for 3 weeks, weekly for 3 weeks, bi-weekly for 3 weeks and monthly for 6 months to monitor for ongoing compliance. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be***	

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	severe cognitive impairments and required extensive assistance for transfer, dressing, hygiene and bathing. On 7/26/12 at 12:15 p.m., the DON (Director of Nursing), who had recently started employment at the facility, was interviewed and indicated she could not find documentation to show the 6/11/12 bruise on the left foot was investigated for causative factors. The DON indicated the staff who noted the bruise were no longer employed by the facility. 3. The clinical record of Resident #B was reviewed on 7/25/12 at 1:45 p.m. and indicated the resident was admitted to the facility on 10/15/09, with diagnoses which included but were not limited to dementia and diabetes mellitus. A non-pressure skin evaluation report, dated 5/3/12 at 3:37 a.m., indicated Resident #B had new bruises on the left index finger by the knuckle, measuring 2.5 cm by 2 cm; at the tip of the finger, measuring 1.5 cm by 1 cm; right forearm, measuring 1.5 cm and 1 cm distally and a second area on the right forearm, measuring 3 cm by 2.5 cm. The Minimum Data Set Assessment, dated 6/13/12, indicated the resident had severe cognitive impairments and		***completed:*** Compliance Date: 8/25/12.	

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	required extensive assistance for transfer, dressing, hygiene and toileting. On 7/26/12 at 12:15 p.m., the DON (Director of Nursing), who had recently begun employment at the facility, was interviewed and indicated she could not find documentation of an investigation of causative factors, related to the 5/3/12 bruises on the left index finger and right forearm. The DON indicated the staff who noted the bruise were no longer employed by the facility. 4. The clinical record of Resident #C was reviewed on 7/25/12 at 10:00 a.m., and indicated the resident was admitted to the facility on 12/15/11, with a diagnosis which included but was not limited to dementia with behavioral disturbances. The Minimum Data Set Assessment, dated 5/30/12, indicated the resident had severe cognitive impairments and required extensive assistance for transfers. A late entry nursing note on 7/17/12 at 11:48 a.m., for 7/12/12 at 2:30 p.m., indicated Resident #C had several areas of bruising on the bilateral upper extremities and bilateral lower extremities. The nursing note indicated the areas of bruising were noted on a shower sheet and the physician was			

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	notified. On 7/26/12 at 12:20 p.m., the Corporate Nurse was interviewed. She indicated Resident #C's bruises, identified on 7/12/12, were noted on a shower sheet on 7/12/12 and an investigation was initiated but was never completed. The Corporate Nurse indicated that after a bruise is identified, a skin sheet should be initiated which ensures follow up assessments will be done. The Corporate Nurse further indicated an Event Investigation/Questionnaire should be completed, which includes interviewing staff involved in the care of the resident, to determine when and how the bruise occurred. The Corporate Nurse indicated the Event Investigation/Questionnaire included a summary of the investigation. On 7/26/12 at 11:00 a.m., the Administrator was interviewed during the abuse protocol review and indicated all injuries of unknown origin should be investigated. The policy for Unusual Occurrences, Revised 12/2009, provided by the DON, was reviewed on 7/26/12 at 12:30 p.m., and indicated the facility would investigate and report resident and visitor unusual occurrences.			

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	The definition of an unusual occurrence/event included, in part: "INJURIES OF UNKNOWN SOURCE An injury should be classified as an injury of unknown source when both of the following conditions are met: 1. The source of the injury was not observed by any person or the source of the injury could not be Explained by the resident AND 2. The injury is suspicious because of the extent of the injury or the location...or the number of injuries observed at one particular point in time or the incidence of injuries over time (multiple bruises, repeat bruises)." This Federal tag relates to Complaint IN00111956. 3.1-28(d)			

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F0309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A. Based on interview and record review, the facility failed to ensure bowel movements were documented in order to provide effective bowel management for 5 of 5 residents whose bowel functioning records were reviewed in a sample of 12. (Residents #G, #H, #I, #J, and #M) B. Based on observation, interview and record review, the facility failed to comprehensively assess the skin condition of a resident upon admission. This deficiency affected 1 of 3 residents whose skin assessments were reviewed in a sample of 12. (Resident #M) Finding include: A.1. On 7/23/12 at 4:00 p.m., the bowel movement records, provided by the DON (Director of Nursing), for Residents #G, #H, #I, #J and #M, were reviewed, and indicated the following:	F0309	**F309 – Provide Care/Services for Highest Well Being** It is the practice of this provider to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident G, H, I, J:* documentation in each resident's clinical record indicates they are having regular bowel functions. Physicians were notified for each resident and when necessary new orders were received for PRN interventions for bowel aides. *Resident M:* has been discharged from the facility. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All residents have the potential to be affected by these findings. A facility audit will be completed by the Nurse Management Team.	08/25/2012

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	1. Resident #H had a span of 10 days, between 7/9/12 and 7/18/12, without any bowel movements recorded. The Care Plan, dated 7/24/12, indicated Resident #H was at risk for constipation due to decreased mobility. The Clinical record of Resident #H was reviewed on 7/24/12 at 10:00 a.m. On 5/10/12, a facsimile was sent to the physician which indicated Resident #H's "bm's (bowel movement's) are hard & (and) difficult for her to pass..." On 5/10/12, an order was received for Colace 100 mgs every day. 2. Resident #G had a span of 16 days, between 7/2/12 and 7/17/12, without any bowel movements recorded. A Care Plan, dated 7/24/12, indicated Resident #G was at risk for constipation related to decreased mobility and decreased gastrointestinal mobility secondary to natural aging. 3. Resident #I had a span of 11 days, between 7/7/12 and 7/17/12, without a bowel movements recorded. A Care Plan, dated 7/24/12, indicated Resident #I was at risk for constipation related to decreased mobility and decreased gastrointestinal mobility secondary to the natural aging process. 4. Resident #J had a span of 12 days,		This audit will review all resident BM Records to ensure documentation is present regarding each resident's bowel function. It will also ensure physician's orders are present for PRN bowel aide interventions for residents not having bowel movements for 3 consecutive days. Any concerns identified will be addressed immediately. In addition, all new admissions will be reviewed to ensure that a head to toe skin assessment has been completed and any skin issues or concerns noted on this assessment are clearly documented and followed up with according to policy. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A nursing in-service will be held on or before 8/25/12. The DNS/designee is responsible for conducting this in-service. This in-service will include review of the facility policy titled, "Bowel Elimination". This in-service will also include re-education regarding BM documentation in the clinical record daily by the direct care staff. In addition, a resident bowel report will be completed daily by the DNS/designee. Any resident having gone 3 consecutive days without a bowel movement will be administered a bowel aide per individual resident's physician order. In addition, the nurses will	

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	155695	A. BUILDING 00 B. WING	07/26/2012

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	between 6/28/12 and 7/8/12, without any bowel movements recorded. A Care Plan, dated 7/24/12, indicated Resident #J was at risk for constipation related to decreased mobility and decreased gastrointestinal mobility secondary to natural aging. 5. Resident #M had a span of 11 days, between 7/11/12 and 7/21/12, without any bowel movements recorded. A Care Plan, dated 7/24/12, indicated Resident #M was at risk for constipation related to decreased mobility, and a terminal diagnosis of advanced lung cancer. The Bowel Elimination policy, dated 6/2012, provided by the DON (Director of Nursing) was reviewed on 7/24/12 at 9:30 a.m., and indicated; "...4. Bowel movements will be recorded on the facility EMR (Electronic Medical Record) and/or record daily by the direct care staff. 5. The DNS (Director of Nursing Services)/designee will assign a charge nurse on a specific shift to review all BM (Bowel Movement) records on a daily basis. 6. A resident bowel report will be completed by the assigned charge nurse of resident(s) who have not had a bowel		be re-educated on the procedure related to full skin assessments with all newly admitted residents including appropriate follow up documentation, measurements and completion of skin sheets. The Nurse Management Team is responsible for reviewing all new admission documentation during the clinical meeting to ensure documentation is present, accurate and followed up with per facility policy. Any noted concerns, omissions or errors will be corrected and/or clarified at the time noted. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** To ensure ongoing compliance with this corrective action, the DNS/designee will be responsible for completion of the CQI Audit Tool titled, “Bowel Elimination” and the CQI Tool titled, “Admission/Readmission Procedure”. Both tools will be completed daily for 3 weeks, weekly for 3 weeks, bi-weekly for 3 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 8/25/12.	

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	movement for 3 consecutive days. 7. Any resident not having a bowel movement for 3 consecutive days, will be given a laxative or stool softener, as prescribed by the physician, at the end of the 3rd day. On 7/24/12 at 9:30 a.m., the DON was interviewed and indicated she had determined nurse aides were not documenting bowel movements and nurses were not reviewing the bowel movement records. She indicated an inservice was being conducted regarding the bowel elimination policy for recording and monitoring bowel movements. B.1. On 7/22/12 at 3:00 p.m., during the orientation tour, RN #11, indicated Resident #M was receiving hospice care and had gangrene of his left foot. On 7/24/12 at 1:30 p.m., the resident's left foot was observed to be dangling off the edge of the bed. The dressing had loosened on the left foot/left lower leg and his left heel was exposed. The left heel was observed to be discolored/blackened. On 7/24/12 at 1:35 p.m., LPN #12 indicated she had replaced the dressing that morning and she would rewrap			

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	Resident #M's left foot. The clinical record of Resident #M was reviewed on 7/24/12 at 3:00 p.m., and indicated the resident was admitted to the facility from the hospital on 6/9/12, with diagnoses which included but were not limited to, lung cancer with metastasis to the brain and ischemia of the lower left extremity. The Hospital History, dated 6/4/12, indicated Resident #M's left foot "...has become more painful and has developed gangrenous changes. The ends of 3 of his toes are very purplish and obviously gangrenous in nature with skin breakdown..." The facility Admission Nursing Assessment, dated 6/9/12, indicated the resident had discolorations on the first, second, third, and fifth toes of the left foot and scabs on the left knee and ankle. The Admission Assessment Report Form indicated "If areas of skin integrity alteration (wound and non-wound) are noted on admission measure each area and complete a skin sheet." There was no documentation the non-wound areas were measured or that skin sheets were initiated upon admission.			

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	On 6/20/12, 11 days after admission, the left foot was comprehensively assessed and skin sheets were initiated. The following areas were noted on the left foot and leg: "Area #1 "Unstageable area to left inner ankle measuring 6 cm X 6 cm which is "l" shaped and presents with black eschar to entire area..." Area #2 Unstageable area to the Left Achilles ...which measures 4.5 cm X 2.5 cm which presents with black eschar.. Area #3 Unstageable area to the Left Outer Ankle which measures 0.5 cm X 0.5 cm and presents with black eschar... Area #4 Unstageable area to the Left Superior Calf which measures 1.8 cm X 0.6 cm and presents with black eschar... Area #5 Unstageable area to Inferior Calf which measures 1.8 cm X 0.6 cm and presents with black eschar... Area #6 Unstageable left foot encompassing all 5 digits of left foot presents with black eschar encircling all digits... It was unclear if the above areas were present upon admission.			

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	On 7/25/12 at 9:30 a.m., the DON (Director of Nursing) was interviewed. The DON indicated she could not find any documentation skin sheets and measurements were done when Resident #M was admitted and indicated the first skin sheets/measurements were done on 6/20/12. The DON indicated at the time Resident # M was admitted, skin sheets should have been completed but there was a change of staff responsible for assessing wounds. The Skin Management Program, dated 3/2010, provided by the DON was reviewed on 7/26/12 at 9:30 a.m., and indicated, in part, "...1. A head to toe assessment will be completed by a licensed nurse upon admission... All alterations in skin integrity will be documented in one of two skin evaluation reports depending on the type of wound-either pressure wound...or other wound..." This Federal tag relates to Complaint IN00111956. 3.1-37(a)			

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F0323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to assure a resident was supervised while on the commode resulting in a fall without injury. This deficiency affected 1 of 6 residents, whose fall were reviewed, in a sample of 12. (Resident #M) Findings include: On 7/22/12 at 3:00 p.m., during the orientation tour, RN #11, indicated Resident #M was receiving hospice care, had gangrene of his left foot and had a fall about a month ago. RN #11 indicated the resident had fallen off the commode. The clinical record of Resident #M was reviewed on 7/24/12 at 3:00 p.m., and indicated the resident was admitted to the facility on 6/9/12, with diagnoses which included but were not limited to, lung cancer with metastasis to the brain and ischemia of the lower left extremity. The MDS (Minimum Data Set)	F0323	**F323 – Free of Accident/Hazards/Supervision/ Devices** It is the practice of this facility to ensure that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident M:* has been discharged from the facility. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** Any resident requiring assistance and/or supervision with transfers has the potential to be affected by this finding and will be identified through an audit of each resident's current transfer needs. This information will be compared to the falls care plan and Nurse Aide Assignment Sheet for each resident. This audit will ensure all direct care staff are providing assistance and/or supervision with transfers for any resident requiring it.	08/25/2012

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	Assessment, dated 6/26/12, indicated the resident had moderate cognitive impairments and required extensive assistance for transfers and toileting. The fall care plan, dated 6/20/12, indicated the resident was at risk for falls due to weakness. The care plan included the following interventions: call light in reach, environmental changes as needed, non skid foot wear, and personal items in reach. On 7/2/12, a careplan intervention was added which indicated "do not leave resident on toilet or bedside commode unattended." A Fall Event Report, dated 7/1/12 at 9:10 a.m., indicated Resident #M had been on the commode and was found lying on left knee and right elbow next to his bed. The Fall Event Report indicated the fall was unwitnessed and that the resident was not injured. On 7/2/12 at 4:55 p.m., an IDT (Interdisciplinary Team) note indicated the resident "slid off bed side commode and was heard yelling for help. CNA observed Resident laying on floor. resident (sic) stated he started to fall asleep when he slipped off the bedside commode and landed on his left knee..."		***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A nursing in-service will be held on or before 8/25/12. The DNS/designee is responsible for conducting this in-service. This in-service will review the facility policy titled, "Fall Management Program". This in-service will also include review of the care plan process and importance of adherence to established care plans and safe practices in regards to providing appropriate level of assistance and/or supervision for all transfers. Any change in resident transfer needs is identified during daily clinical meetings. Changes are communicated to direct care staff promptly through updates to care plans and Nurse Aide Assignment Sheets. Each shift, Charge Nurse to do rounds to ensure C.N.A. Assignment Sheets are being followed which includes resident not being left alone on a bedside commode. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** To ensure compliance with these corrective actions, the DNS/designee will complete the CQI Audit Tool titled, "Fall Management" daily for 3 weeks, weekly for 3 weeks and monthly	

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	The IDT note indicated "...When resident is placed on bedside commode or in bathroom that nursing staff... will be with resident at all times..." On 7/26/12 at 10:30 a.m., the DON (Director of Nursing), indicated Resident #M should not have been left alone on the commode. The DON indicated staff were educated and the resident's care plan was updated after the incident. This Federal tag relates to Complaint IN00111956. 3.1-45(a)(2)		for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 8/25/12.	

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F0502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on observation, interview and record review, the facility failed to ensure the laboratory picked up a stool specimen after it was obtained. This deficiency affected 1 of 1 resident reviewed, who had a stool specimen ordered, in a sample of 12. (Resident #D) Findings include: On 7/22/12 at 6:30 p.m., Resident #D was observed in the assisted dining room. The resident would shake her head, no, when staff offered to give her bites of the food. The clinical record of Resident #D was reviewed on 7/23/12 at 3:00 p.m. and indicated the resident was admitted to the facility on 7/30/07, with diagnoses including but not limited to, vascular dementia, and diabetes mellitus. On 7/20/12 at 9:45 p.m., nursing notes indicated, "This nurse was notified by CNA (Certified Nursing Assistant) that resident had diarrhea and had a foul odor..." The nursing note indicated the nurse assessed the resident's stool, and	F0502	**F502 – Administration** It is the practice of this facility to provide or obtain laboratory services to meet the needs of the residents. The facility is responsible for the quality and timeliness of these services. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident D:* has been discharged from the facility. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** Any resident requiring laboratory services has the potential to be affected by this finding. A facility audit will be completed by the Nurse Management Team. This audit will review all residents with lab orders to ensure all labs and specimens are obtained and picked up by the lab as ordered. Physician orders are reviewed by the Nurse Management Team. All physician orders related to labs will be cross checked to the Lab Requisition Form by the Medical Records Clerk/designee to ensure labs and specimens are obtained and sent to the lab for	08/25/2012

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	notified the physician. Physician orders, dated 7/20/12, indicated, the following: a stool specimen was to be obtained and the physician was to be notified of the results; Flagyl (an antibiotic) 250 mgm was to be administered every day for five days; and the physician was to be notified if diarrhea persisted. A microbiology laboratory requisition form, dated 7/20/12 at 8:30 p.m., indicated the resident's stool was to be tested for Clostridium difficile antigen toxins A and B. The July 2012 MAR (Medication Administration Record) indicated the stool specimen was obtained on 7/20/12. Nursing notes indicated the resident had no further documented loose stool until 7/23/12 at 9:39 a.m. On 7/23/12 at 3:15 p.m., LPN #10, who had obtained the stool specimen, was interviewed. LPN #10 indicated she had obtained the specimen on 7/20/12, but the laboratory never picked up the specimen. On 7/23/12 at 5:33 p.m., nursing notes indicated the physician was notified that		processing as ordered. Any discrepancies will be corrected and/or clarified when noted. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A nursing in-service will be held on or before 8/25/12. The DNS/designee is responsible for conducting this in-service. This in-service will include review of the procedure related to obtaining labs and specimens and will emphasize the importance of ensuring labs and specimens are obtained and sent to the lab for processing timely and as ordered. All physician orders related to labs will be cross checked to the Lab Requisition Form by the Medical Records Clerk/designee to ensure labs and specimens are obtained and sent to the lab for processing as ordered. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** Ongoing compliance with this corrective action will be monitored through the facility CQI Program. The DNS/designee will be responsible for completion of the CQI Tool related to Lab Services daily for 3 weeks, weekly for 3 weeks and monthly for 6 months. If threshold of 90% is not met, an action plan will be developed. Findings will be	

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	the stool specimen had not been obtained and the physician was updated on the resident's current condition, which included poor oral intakes and a change in vital signs. The nursing notes further indicated the physician ordered Resident #D be transferred to the hospital for evaluation. On 7/23/12 at 6:32 p.m., nursing notes indicated the resident was transferred to the hospital and was subsequently admitted. On 7/24/12 at 9:00 a.m., the DON (Director of Nursing) indicated she had contacted the laboratory and they acknowledged they had been notified about the stool specimen on 7/20/12, but they offered no explanation as to why they had not picked up the specimen. This Federal tag relates to Complaint IN00111956. 3.1-49(a)		submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 8/25/12.	

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F0514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
	Based on interview and record review, the facility failed to document baths/showers. This deficiency affected 6 of 8 residents, whose bath records were reviewed, in a sample of 12. (Residents #B, #I, #C, #E, #G, #J) Findings include: On 7/26/12 at 11:00 a.m., The DON (Director of Nursing) was interviewed and indicated they did not have a specific policy for showers/baths, but they were offered at least twice weekly to each resident. The DON indicated CNAs (Certified Nursing Assistants) were to fill out a shower sheet every time a shower or bath was offered even if it was refused. The DON indicated she checked the shower sheets for individual residents against the shower schedule for July 2012	F0514	**F514 – Records – Completed/Accurate/Accessible** It is the practice of this provider to maintainclinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systemically organized and that contain sufficient information to identify the resident.***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *Resident B, I, C, E, G, & J:* have been receiving routine shower/bath care. These residents experienced no negative outcome as a result of this finding. ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** All	08/25/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155695	A. BUILDING 00 B. WING	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE VILLAGE	1400 W FRANKLIN ST ELKHART, IN 46516

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and many of the requested shower/bath sheets, for dependent Residents #B, #I, #C, #E, #G, and #J, were missing. The DON indicated, as a result, she had no documentation the showers or baths were given. She indicated she felt the baths/showers were provided, but the staff failed to document them. On 7/26/12 at 11:25 p.m., The July 2012, Shower/Bath sheets for Residents #B, #I, #C, #E, #G, and #J were reviewed with the DON and indicated the following: Resident #B had four shower/bath sheets missing and as a result, no documentation showers or baths were given or refused on 7/4, 7/7, 7/11, and 7/14/12. Resident #I had two shower/bath sheets missing and as a result, no documentation showers or baths were given on 7/9, and 24/12 Resident #C had four shower/bath sheets missing and as a result, no documentation showers or baths were given on 7/4, 7/7, 7/11, and 7/14/12 Resident #E had three shower/bath sheets missing and as a result, no documentation showers or baths were given on 7/6, 7/10, and 7/13/12.		residents have the potential to be affected by this finding. Shower sheets will be reviewed by the Nurse Management Team during the clinical weekday meeting and compared to the daily shower schedule. Any resident noted to have missing documentation related to shower/bath care will be investigated and corrected/rectified at the time noted. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** A nursing in-service will be held on or before 8/25/12. The DNS/designee is responsible for conducting this in-service. This in-service will include review of the facility procedure related to resident care including showers and bathing assistance. This in-service will emphasize the importance of daily documentation by direct care staff related to showers and bathing care. Charge Nurses will be responsible for ensuring that showers/baths are given as scheduled and that appropriate documentation has been completed prior to the conclusion of each shift. Shower sheets will be reviewed by the Nurse Management Team during the clinical weekday meeting and compared to the daily shower schedule. Any resident noted to have missing documentation related to shower/bath care will	

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	Resident #G had two shower/bath sheets missing and as a result, no documentation showers or baths were given on 7/19 and 7/23/12 Resident #J had two shower/bath sheets missing and as a result, no documentation showers or baths were given on 7/10 and 7/24/12. All of the residents whose bath records were reviewed, had severe to moderate cognitive impairments and required extensive assistance for bathing. This Federal tag relates to Complaint IN00111956. 3.1-50(a)(1)		be investigated and corrected/rectified at the time noted. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** The DNS/designee will be responsible for completion of the CQI Tool titled, "Accommodation of Needs" daily for 3 weeks, weekly for 3 weeks and monthly for 6 months to monitor for ongoing compliance. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the CQI Committee for review and follow up. ***By what date the systemic changes will be completed:*** Compliance Date: 8/25/12.	